ATTACHMENT B

Summary of Fiscal Intermediary Billing of Non-Covered Charges

Purpose: This document summarizes existing instructions related to the billing of non-covered charges by providers submitting fee-for-service claims to Medicare fiscal Intermediaries (FIs) or regional home health intermediaries (RHHIs). While inpatient facilities have been able to bill these charges for some time, Medicare systems have only had end-to-end capacity to process non-covered charges for outpatient providers on claims with other covered charges as of April 2002 (prior transmittals: A-01-130, A-02-071, A-02-117 and A-03-039).

This document does provide some new instructions, but only to the extent that current instructions did not provide enough specificity on certain aspects of billing or failed to apply broad concepts to all bill types, especially in association with liability-related notices such as the advance beneficiary notice (ABN). New instructions or clarifications are noted as they arise, and citations are given for pertinent existing instructions that are not supplanted by this instruction.

The ABN, and other similar notices such as the Home Health (HH) ABN, only serve to ensure that providers can shift liability under §1862(a)(1) and 1879 of the Social Security Act (the Act) when billing for services delivered to Medicare beneficiaries, that are usually covered as part of established Medicare benefits, but are thought not to be covered for a specific reason stipulated in the ABN. Denials under §1862(a)(1) can relate to services not being reasonable and necessary, home care given to someone who is not homebound or hospice care given to someone not terminally ill.

I – Notification Requirements Related to Non-Covered Charges – PRIOR to Billing

A. Payment Liability Conditions of Billing [Table 1]. Before delivering any service, providers must decide which one of the following three conditions apply in order to properly inform Medicare beneficiaries as to their potential liability for payment according to notice requirements explained below:

TABLE 1:

CONDITION 1	CONDITION 2	CONDITION 3
Services are **statutory exclusions** (ex., not defined as part of a specific Medicare benefit) and **billed as non-covered,** or billed as non-covered for another specific reason not related to §1862(a)(1) and §1879 of the Act (see below)	A reduction or termination in previously covered care, or a determination of coverage related to §1862(a)(1) and §1879 of the Act, will require a notice of non-coverage, ABN or HHABN, **OR** a beneficiary requests a Medicare determination be given for a service that **MAY be non-covered; billing of services varies**	Services **billed as covered** are neither statutorily excluded nor require a liability notice be given
Potential liability: Beneficiary, as services are **always** submitted as non-covered and therefore **always denied** by Medicare	**Potential liability: Beneficiary, subject to Medicare determination**, on claim: If a service is found to be covered, the Medicare program pays	**Potential liability: Medicare, unless** service is denied as part of determination on claim, in which case liability may rest with the beneficiary or provider

NOTE: Only one of these conditions can apply to a given service.

Billing FOLLOWS the determination of the liability condition and notification of the beneficiary (if applicable based on the condition). **To the extent possible in billing, providers should split claims so that one of these three conditions holds true for all services billed on a claim, and therefore no more than one type of beneficiary notice on liability applies to a single claim.** This approach should improve understanding of potential liability for all parties and speed processing of the majority of claims.

> **EXCEPTION:** Cases may occur where multiple conditions may apply and multiple notices could be necessary. These are most likely to occur with claims paid under the outpatient prospective payment system (OPPS, §170 of Chapter 4 of the Medicare Claims Processing Manual). The OPPS requires all services provided on the same day to be billed on the same claim, with few exceptions as already given in OPPS instructions (i.e., claims using condition codes 21, 20, discussed below, or G0). Modifiers used to differentiate line items on single claims when multiple conditions or notices apply are discussed below.

Liability is determined between providers and beneficiaries when Medicare makes a payment determination by denying a service. **With this instruction, such determinations must always be made on items submitted as non-covered (i.e., properly submitted non-covered charges are denied).**

A rejection or "return to provider" (RTP) does not represent a payment determination. However, beneficiaries cannot be held liable for services that are never properly billed to Medicare, such that a payment determination cannot be made (i.e., a payment or a denial of payment). Rejected or RTPed claims can be corrected and re-submitted, permitting a determination to be made after resubmission.

This instruction focuses on issues of liability related to denials of charges submitted as non-covered. The FIs/RHHIs should not advise providers to independently cancel or adjust finalized claims, such as when a line submitted as non-covered is denied, especially when a medial review determination or payment group or level would be altered. Other than exceptions noted in §130, Adjustments, in Chapter 1 of the Medicare Claims Processing Manual, denied claims cannot be adjusted or resubmitted, since a payment determination cannot be altered other than by reconsideration or appeal, though providers may contact their FI/RHHI in cases of billing errors (i.e., a date typing error detected after finalization). In such cases, the FI/RHHI can consult with the provider and cancel the claim in entirety, so that the provider can then replace the cancelled claim with a new and correct original claim.

Payment Liability Condition 1. There is no **required** notice if beneficiaries elect to receive services that are excluded from Medicare by statute, which is understood as not being part of a Medicare benefit, or not covered for another reason that a provider can define, but that would **not** relate to potential denials under §§1879 and 1862 (a) (1) of the Act. **However, note that applicable Conditions of Participation (COPs) MAY require a provider to inform a beneficiary of payment liability BEFORE delivering services not covered by Medicare, IF the provider intends to charge the beneficiary for such services.** Some examples of Medicare statutory exclusions include hearing aides, most dental services and most prescription drugs for beneficiaries with fee for service Medicare.

In addition to what may be required by the COPs, providers are advised to respect Medicare beneficiaries' right to information as described in "Medicare and You" [the Medicare handbook], by alerting them to potential payment liability. If written notification of potential liability for statutory exclusions is either required or desired, an explanation and sample voluntary notice suggested for this purpose can be found at the Centers for Medicare and Medicaid Services (CMS) Web site (see Notices of Exclusions from Medicare Benefits, NEMB):

www.cms.hhs.gov/medlearn/refabn.asp

When such a notice is given, patient records should be documented. If existing, any other situations in which a patient is informed a service is not covered, should also be documented, making clear the specific reason the beneficiary was told a service would be billed as non-covered.

Payment Liability Condition 2. Providers **must** supply a notice of non-coverage, ABN or HH ABN if services delivered to a Medicare beneficiary are to be reduced or

terminated following delivery of covered care, or thought not to be covered under §1862 (a) (1) of the Act, in order to shift liability under §1879 of the Act. Providers must give these notices **before** services are delivered for which the beneficiary may be liable. **Failure to provide such notices when required means the provider will not be able to shift liability to the beneficiary.**

There are **three** different types of such notices, given in different settings for specific types of care:

(1) Notices of non-coverage are given to eligible inpatients receiving or previously eligible for non-hospice services covered under Medicare Part A (types of bill (TOB) 11x, 18x, 21x, and 41x) but services at issue no longer meet coverage guidelines, such as for exceeding the number of covered days in a spell of illness. In hospitals, these notices are known as Hospital Issued Notice of Non-coverage (HINNs) or hospital notices of non-coverage, in Skilled Nursing Facilities (SNFs), they may be known as Sarasett notices. Providers have flexibility in delivering this notice: **CMS does not require a discrete form for this purpose. Beneficiaries in these settings never receive ABNs.** Existing instructions regarding such notices can be found at:

- Chapter 3 (Inpatient Hospital), §40.5, of the MCPM (these notices have been called HINNs);
- Chapter 6 (Inpatient SNF), §40.6.5, of the MCPM; and
- Chapter 30 (Limitation of Liability), §30.1, 40, 50, of the MCPM.

NOTE: Medicare instructions-- Manuals and Program Memoranda (PMs)-- are accessible at the following website:

www.cms.hhs.gov/manuals/

(2) ABNs and (3) HHABNs are specific forms required by Medicare for providers to give to beneficiaries when: **(a)** Overall medical necessity of a recognized Medicare benefit is in doubt, under §1879 and §1862 (a) (1) of the Act, or **(b)** Care that was previously covered is to be reduced or terminated, usually because medical necessity for the service is doubted by the provider, or **(c)** The setting is inpatient such that other inpatient notices of non-coverage are not applicable: **These forms are used for Part B and hospice services ONLY.** Current ABN forms and instructions can be found on the CMS Web site on the ABN home page at:

- www.cms.hhs.gov/medicare/bni

OR

- **Chapter 30 (Limitation of Liability) in the MCPM.**

Payment Liability Condition 3. This condition is the case in which providers are billing for what they believe to be covered services as covered services. There are no notice requirements just for this condition, and non-covered charges are not involved. However, as mentioned before, there are cases in which covered and non-covered charges are submitted on the same claim, which will be discussed further below (sections III. A. and D. below).

B. Summary of Notices by Provider Type [Table 2]

TABLE 2:

CONDITION	Notice	Type of Provider
Payment Liability Condition 1	No notice requirement-- unless COPs require--not covered for reasons other than statute, §§1862(a)(1) and 1879 of the Act do not apply - documenting records recommended	**All providers**
Payment Liability Condition 1	Optional notice of services excluded by statute (ex., not part of a recognized Medicare benefit, may use NEMB)	**All providers** when service known not to be covered by law by the Medicare fee-for-service program
Payment Liability Condition 2	Notice of Non-Coverage	**Inpatient only (TOBs: 11x, 18x, 21x, 41x)**
Payment Liability Condition 2	HHABNs (Form CMS-R-296)	**Home Health (HH) services under a HH plan of care** and paid through the HH prospective payment system (PPS) **only (TOBs 32x and 33X)**
Payment Liability Condition 2	ABNs (Form CMS-R-131-L)*	Laboratories or providers billing lab tests **only (revenue codes 30x, 31x and 92x)**
Payment Liability Condition 2	ABN (Form CMS-R-131-G)	**All other providers and services**, outpatient and inpatient Part B, not previously listed in this chart for Condition 2, that bill FIs or RHHIs, including HH services ***not*** under a plan of care, and hospice services paid under Part A
Payment Liability Condition 3	No notice requirement	**All providers**

*** Use of this version of the form is optional. Providers delivering same-day lab and non-lab services related to an ABN may use CMS-R-131-G for both.**

II – Inpatient Billing – Non-Covered Charges

No Payment Inpatient Hospital and SNF Claims. Where stays begin with a non-covered level of care and end with a covered level, only one claim is required for both the non-covered and covered period, which must be billed in keeping with other billing frequency guidance (i.e., SNFs are required to bill monthly). However, SNFs and inpatient hospitals are required to submit discharge bills in cases of no-payment. These bills must correctly reflect liability. SNFs may use a single bill for a period of non-coverage for which the provider is liable, another for the period for which the beneficiary is liable. For SNFs, provider-liable no payment bills should be submitted **before** discharge in order to assure utilization chargeable periods are clearly posted. For inpatient hospital PPS claims that cannot be split, hospital providers can submit occurrence span code 77 which should be used for provider-liable non-covered periods, and occurrence span code 76 for beneficiary-liable non-covered periods.

These procedures must be followed for Part A inpatient services (**TOBs: 11x (hospital), 18x (swing bed), 21x (SNF), 41x (Religious Non-medical Health Care Institutions—RNHCI)**), but are not required for inpatient Part B. These no payment bills contain:

- **All charges** submitted as **non-covered;**
- **Frequency code 0** (zero) to be used in the third position of the type of bill (TOB) form locator of the claim [**NOTE**: If providers do not submit no payment claims with this frequency code, the standard systems will already act to change the frequency code to 0];
- **Total charges** equal the sum of non-covered charges; and
- **Basic required claim elements** must be completed.

Note units are not required when reporting non-covered days on SNF and Inpatient Rehabilitation claims using Health Insurance Prospective Payment Systems (HIPPS) codes.

Claims that do not conform to these requirements will be returned to providers. **For SNF**, occurrence code 22 should **also** be used on no payment claims when SNF care is reduced to a non-covered level and benefits had previously been exhausted. This instruction is consistent with §40.7, Chapter 6 (Inpatient SNF) in the MCPM.

Current instructions for inpatient no-payment claims are found in the following locations:

- §40.7, Chapter 6 (Inpatient SNF), in the MCPM; and
- §40.4, Chapter 3 (Inpatient Hospital), in the MCPM.

NOTE: Though discussed under Section III below on outpatient claims, inpatient claims may also be submitted using condition codes 20 and 21 in keeping with current billing practices. For example, a demand bill using condition code 20 may be used for SNF or hospital inpatient billing once a notice of non-coverage is provided. **Also, see III. D. 2. below for new inpatient demand billing instructions for hospitals.**

III – Outpatient Billing: Billing Non-Covered Charges (TOBs other than 11x, 18x, 21x and 41x)

The term "outpatient" is used very generally in this instruction. From this point forward in this document, the term should be applied to benefits that are **both:** (1) **Not** exclusively inpatient, AND (2) **Not** Part A TOBs (i.e., **not** TOBs11x, 18x, 21x, 41x). Therefore, "outpatient" here includes inpatient Part B (TOBs 12x, 22x) and hospice (TOBs 81x, 82x)-- see Attachment A for a complete TOB list. Occasionally, inpatient claims are also discussed in this section, but they are specifically cited whenever guidance is also applicable to these bill types.

A. Services Excluded by Statute

Medicare will not pay for services excluded by statute, which often are services not recognized as part of a covered Medicare benefit. Examples of such services are given to beneficiaries in the "Medicare and You" handbook, at the end of the "Part A/Part B Cost and Coverage" subsection under Section 4 on the "Original Medicare Plan". Such services cannot necessarily be recognized in the definition of a specific procedure or diagnosis code. For example, under some conditions, a given code may be covered as part of a given benefit, but under other cases when no benefit is applied, the same code would not be covered. For claims submitted to FIs/RHHIs, these services may be: **(1)** Not submitted to Medicare at all, **(2)** Submitted as non-covered line items, or **(3)** Submitted on entirely non-covered claims.

1. Medicare does not require procedures excluded by statute be billed *unless*: (a) Established policy requires either all services in a certain period, covered or non-covered, be billed together so that all such services can be bundled for payment consideration (i.e., procedures provided on the same day to beneficiaries under OPPS), or billing is required for reasons other than payment (i.e., utilization chargeable in inpatient settings); or **(b) A beneficiary requests** Medicare be billed in a manner that the service in question will be reviewed by Medicare (more on demand billing in III. D. below).

2. To submit a **non-covered line item** on a claim with other covered services (Payment Liability Conditions 1 and 3), use the modifier –GY on all line items for statutory exclusions. Submit all charges for those item(s) as non-covered charges, and otherwise complete the claim as is appropriate for the covered charges. More information is given on the –GY modifier (see III. G. below). **This option should only be used when providers are unable to split non-covered services onto a separate claim ((3) below).**

3. To submit statutory exclusions on **entirely non-covered claims** (Payment Liability Condition 1 only), use condition code 21, a claim-level code, signifying all charges that are submitted on that claim are non-covered charges. No –GY modifiers need be attached to any of the procedure codes on such a claim, and **all**

charges must be submitted as non-covered (see general billing requirements under Other Uses of No-Payment Claims with Condition Code 21, in III. B.2. below).

B. Other Uses of No Payment Claims with Condition Code 21

Condition code 21 can be employed to indicate no payment outpatient claims are being submitted for other reasons in addition to III. A. above:

- At a beneficiary's, or other insurer's, request, to obtain a denial from Medicare on any kind of non-covered charges, to facilitate payment by subsequent insurers (e.g., statutory exclusions outside Medicare benefits, such as most self-administered drugs; no modifier is required to establish liability); and
- With an HHABN in special cases (see III. B. 1., immediately below).

1. Custodial Care under HH PPS, or Termination of the Benefit during an Episode Period. The use of no payment claims in association with an HHABN involving custodial care and termination of a benefit during an episode period are **new clarifications of CMS policy**. This clarification does **not** apply to cases in which a determination is being requested as to the beneficiary's homebound status at the **beginning** of an episode; there an ABN must be used if a triggering event occurs. However, in cases where the HH plan of care prescribes **only** custodial care, or if the benefit has terminated during an episode period, **and** the physician, beneficiary and provider are all in agreement the benefit has terminated or does not apply, home health agencies (HHAs) can use:

a. The HHABN for notification of the beneficiary, selecting Option A on that form; and

b. A condition code 21 no-payment claim to bill all subsequent services.

NOTE: Providers can never pre-select ABN options for beneficiaries, in accordance with existing ABN policy. In each case, the beneficiary must be consulted as to the option they want to select. The ABN options presented relative to specific billing scenarios above, and in the rest of the document, are only illustrations and in no authorization for pre-empting a beneficiary's right to choose a specific option.

Special instructions for the preparation of HH PPS no-payment claims can be found in §60, Chapter 10 (Home Health), of the MCPM.

Termination of the benefit during the episode is discussed in III.D. 1. B., below.

2. General Billing Instructions for No-Payment Claims with Condition Code 21 (Other than HH PPS). No payment claims are sometimes referred to **as**

"billing for denials/denial notices". In summary, instructions applicable to all bill types other than HH PPS claims are:

- **Condition code 21 must be used**;
- **All charges must be submitted as non-covered;**
- **No use of modifiers signifying provider liability** (see III. G. below);
- **Frequency code 0** (zero) **must be used** in the third position of TOB of the claim, though the frequency codes 7 and 8 may be used when appropriate for provider-submitted claim adjustments/cancellations;
- **Total charges must equal the sum of non-covered charges**;
- **Basic required claim elements must be completed**; and
- **Statement dates should conform to simultaneous claims for payment**, if any.

If claims do not conform to these requirements, they will be returned to providers. Non-covered charges billed on these claims will be denied, and beneficiaries will be liable.

C. Summary of All Types of No Payment Claims [Table 3]

With this instruction, all entirely non-covered claims submitted to Medicare use frequency code 0 (zero), unless: (1) "7" for adjustments or "8" for cancellations are applicable, or (2) "traditional" condition code 20 demand bills applies. All outpatient, inpatient Part B and hospice TOBs must use either condition code 20 or 21 if claims are submitted as entirely non-covered.

TABLE 3:

Non-covered Indicator for Entire Claim	Table 1 Payment Liability Condition/Notice Requirements	Charges/Provider	Outcome/Liability
Frequency Code 0 on Inpatient Hospital, Swing Bed, RNHCI or SNF Claims	**Condition 1** – Non-covered claim for which provider is liable, **NO notice requirement** **OR** **Condition 1** - Updating utilization of an inpatient benefit with a claim **AND** **Condition 2 - Notice of non-coverage**	All charges submitted as non-covered; use **only for inpatient Part A services (i.e., TOB 11x, 18x, 21x, 41x)**	Medicare will deny all services on such bills; provider or beneficiary liable, but the beneficiary must be given a notice of non-coverage before being held liable*

Non-covered Indicator for Entire Claim	Table 1 Payment Liability Condition/Notice Requirements	Charges/Provider	Outcome/Liability
Condition Code 21 with Frequency Codes 7, 8, 0 (for entire non-covered claim)	**Condition 1** – Voluntary notice of statutory exclusion **OR** any beneficiary or other payer requested billing for denial/no payment claim when **no notice requirement exists** (i.e., §1862(a)(1) or §1879 of the Act do not apply) **OR** **Condition 2 - HHABN, Option A** on form, custodial care only	All charges for all line items on claims using this code must be submitted as non-covered, **all providers can submit****	Medicare will deny all services on these claims in all cases and will hold beneficiary liable for payment on these denials
Condition Code 20 on finalized Outpatient Claims with applicable Frequency Code*, or Frequency Code 7 or 9 on some HH PPS Demand Bills***** (traditional demand billing without ABN – see below)	**Condition 2** – **HHABN** for other than custodial care **OR** beneficiary-requested demand billing when **neither HHABN nor ABN required**	All traditional demand–billed charges must be submitted as non-covered, but other covered services may be submitted on the same claim for the same interval **by all providers**	Medicare will suspend all claims submitted with this code, services may or may not be reviewed, properly informed beneficiaries may be liable for services denied after suspense/ review

* Medicare only requires the beneficiary receive a notice if the denial is based on Condition 2.

** Non-covered claims can only be submitted for OPPS for days where no covered services are provided that same day.

*** Different frequency codes can be used with condition code 20 demand billing, however, entirely non-covered condition code 20 initial demand bills must use frequency code 0 or be HH PPS demand bills; HH PPS demand bills with frequency code 9 may be partially or entirely non-covered.

NOTE: Other than in Part A inpatient cases (TOBs 11x, 18x, 21x, and 41x), providers can submit no payment claims using condition code 21 simultaneously with claims for covered charges for the same beneficiary (i.e.,

split billing of covered and non-covered charges). However, such "simultaneous" claims should not contain any future dates in their statement periods (i.e., from and through dates), and non-covered claims should fit within or be equal to the statement period of simultaneous for payment claims (i.e., not overlap the statement periods of multiple claims). This is because, though unusual, no payment claims may still be appealed, potentially overturned on appeal, and no more than one claim/statement period should be subject to change if this occurs. This is particularly important for claims paid prospectively (i.e., HH PPS).

All submitted non-covered or no payment claims using condition code 21 will be processed to completion, and all services on those claims, since they are submitted as non-covered, will be denied. The default liability for payment of these claims is assigned to the beneficiary, who may then submit the denial from Medicare, as the primary payer, to subsequent payer(s) for consideration. Since a denial is a Medicare determination of payment, all services submitted on no-payment claims may be appealed later if unusual circumstances so warrant. **That is, all payment determinations are subject to appeal, even denials of services submitted as non-covered.**

D. Traditional Demand Bills (Condition Code 20)

Traditional demand bills, a term being coined here to encompass the only billing option existing for demand bills before the ABN with outpatient billing, use condition code 20 to indicate a beneficiary has requested billing for a service, even though the provider of the service has advised the beneficiary Medicare is not likely to pay for this service. That is, there is some dispute as to whether a service is covered or not, because if there is no dispute, billing a no payment claim or other options for non-covered charges may be more appropriate.

In the past, traditional demand billing was not always consistent or used by all providers. There was no notice requirement. Past instructions required 100 percent of specific types of demand bills to be suspended for manual review (inpatient SNF and home health, TOBs 21x, 32x and 33x), and required the provider submit additional documentation for development to enable determination of the medical justification for the service(s) in question.

This process is being revised with this instruction. First, if an ABN is given, special billing requirements apply (see III.E. below), and traditional demand billing should NOT be used. But now, **only in cases when the ABN is NOT given**, **services for which coverage is questioned are submitted as non-covered using traditional demand billing. This process is now open to all provider types, inpatient and outpatient.** The case of demand billing with the HHABN, opposed to the ABN, is discussed under III. D. 1., "Existing Demand Billing Instructions", immediately below.

Even though there are no notice requirements with these demand bills, providers are always encouraged to advise beneficiaries when they may be liable for payment before delivering such services, and may be required to do so by applicable COPs. In such cases, providers should also document their records that such advice has been given.

- See specific instructions and exceptions for inpatient SNF and home health in III. D. 1. a.-c., immediately below; and

- General demand billing instructions for all other provider types are in III. D. 2.

General to all demand billing, use of defective HHABNs and ABNs to effect abusive demand billing is not permitted, since current ABN/HHABN policy states routine use of these forms is **not** acceptable (see §60.4.4.2, Chapter 30 (Limitation of Liability - Financial Liability Protections), of the MCPM). Routine use is defined in current ABN policy, and applies to all ABN forms (i.e., HHABN). If FIs/RHHIs find providers are making such use of the ABN or HHABN, they should first attempt to educate the provider. If the misuse continues, the FI/RHHI should expedite review in all subsequent cases and find the provider liable for all demand billed charges where routine use is made of the ABN or HHABN. Also in such cases, providers cannot retain any funds collected from the beneficiary in advance of a medical review decision on liability on a demand bill once a decision is made the beneficiary is not liable.

Demand billing is resource intensive for the Medicare program, and affects the timeliness of payment determinations, which should prevent conscientious providers from abusing this mechanism when there is no true doubt as to coverage/payment. Routine billing of covered services, or billing of non-covered charges as described in I. and III. A. and B. above, should be used as appropriate when coverage/payment is believed not to be in doubt. The ABNs and HHABN are not needed in these two cases if a triggering event does not occur. Beneficiaries retain appeal rights when these other billing mechanisms are used.

1. Existing Demand Bill Instructions.

The CMS currently requires review and development of 100 percent of HH (TOBs 32x, 33x) and Part A SNF demand bills (TOB 21x).

a. HH PPS. There are special instructions for **HH PPS demand bills**. Such special instructions must be followed if: **(1)** An HHABN is required, or **(2)** If a beneficiary requests demand billing when receiving care from a home health agency (HHA) in an HH PPS episode. Instructions for such bills can be found at:

- §50 of Chapter 10 (Home Health) of the MCPM; and
- Note these HH PPS demand bills use frequency code 9.

Note new exceptions for use of home health no payment bills in place of demand bills are described in III. B. 1., above.

b. Refinements for HH PPS. HHABN policy has continued to change, but current documentation of this policy can be found in:

- The ABN Web site (cited in I. A. above); and
- Chapter 30 (Financial Liability Protections), §60, of the MCPM.

(1) Independent Assessment. Billing questions relative to the HHABN and home health assessments have persisted. With regard to payment liability for the assessment itself, the assessment is a non-covered service that is **not** a Medicare benefit and is **never** separately payable by Medicare. In all cases of statutory exclusions, a choice remains: the provider may or may not decide to hold the beneficiary liable, and Medicare cannot specify which is appropriate because the service at issue is outside Medicare's scope.

If a decision is made to hold a beneficiary liable for just the assessment, CMS believes providers must be in compliance with the home health COPs, as follows:

484.10.e (1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before care is initiated, the HHA must inform the patient, **orally and in writing**, of: (i) The extent to which payment may be expected from Medicare, Medicaid or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual has to pay.

Therefore, while no notice may be required if the provider chooses to be liable, the conditions state **a notice is required if the beneficiary is to be held liable**, and must be delivered **prior** to the service in question. Since the HHABN is **not** appropriate in these cases, the provider is free to develop their own written notice, but Medicare does have a voluntary form, the NEMB (see section I.A. above), that could be used for this purpose.

2. Termination of the Benefit During the Episode Period. The HHABN is likely to be warranted in cases when only non-skilled, not medically necessary or non-covered services remain to be delivered under the plan of care, or when the beneficiary is no longer homebound, during the 60 days of the original episode period. These situations **can** be triggering events under existing HHABN policy (i.e., termination of the benefit), since the close of the episode, or the end of the benefit, occurs at this point, and a Medicare "paper" discharge

can be done (i.e., the final claim for the episode prepared and submitted). At this point two billing options exist:

a. **If there is no doubt the benefit has been completed, meaning the ordering physician, beneficiary and provider agree Medicare coverage has ended, the HHA has the option of billing the balance of the 60 day period remaining after the benefit has ended on a no payment claim as described in section III. B. 1. above.** As with other statutory exclusions or services not part of a recognized Medicare benefit, notification of the beneficiary as to his/her liability prior to delivery of the service if the provider intends to charge may still be required by the HH COPs. A form such as the NEMB can be used in these cases.

b. **If there is doubt/dispute as to the benefit is continuing, the whole60-day episode period must be billed on a single HH PPS demand bill**, and HHABNs must be given when triggering event(s) occur.

3. Billing in Excess of the Benefit. In some states, the Medicaid program will cover more hours of care in a week than the Medicare benefit. Therefore, a HHA may be billing hours/visits in excess of the benefit during a Medicare home health episode for a dually eligible beneficiary. Since the care delivered in excess of the benefit is not part of the benefit, and does not affect the amount of Medicare's prospectively set payment, there is no dispute as to liability, and a HHABN is **not** required unless a triggering event occurs; **that is, care in excess of the benefit is not a triggering event in and of itself requiring an ABN**. Billing services in excess of the benefit is discussed in Chapter 10 (Home Health), §50 C., of the MCPM.

4. One-Visit Episodes. Since intermittent care is a requirement of the Medicare home health benefit, questions often arise as to the billing of one-visit episodes. **Medicare claims systems will process such billings, but these billings should only be done WHEN some factor potentially justifies the medical necessity of the service relative to the benefit**.

Many of these cases do not even need to be demand billed, because coverage is not in doubt, since physician orders called for delivery of the benefit. When the beneficiaries dies after only one visit is a clear-cut example. When physician orders called for additional services, but the beneficiary died before more services could be delivered, the delivery of only one visit is covered. The death is clearly indicated on the claim with use of patient status code 20. Other cases in which orders clearly called for additional services, but circumstances prevented delivery of more than one service by the HHA, are also appropriately billed to Medicare in the same fashion.

There may be rare cases where, even though orders do not clearly indicate the need for additional services, the HHA feels delivery of the service is medically justified by Medicare's standard, and should be covered. **In such situations, when doubt exists, a HHA should still give the beneficiary a HHABN if a triggering event has occurred, explaining Medicare may not cover the service, and then demand bill the service in question.**

No billing is required when there is no dispute that the one service called for on the order does not meet the requirements for the Medicare home health benefit, or is not medically necessary. However, there are options for billing these non-covered services as discussed in III. A-B; note the COPs may require notification in this situation if the beneficiary is to be held liable, as discussed in III. D. 1.b. 1. immediately above.

c. SNF Demand Bills. There are special instructions for inpatient Part A SNF demand bills, which can be found at:

- Chapter 6 (Inpatient SNF), §40.7, of the MCPM; and
- **Note ABN form 131-G, or 131-L for lab services only, are used with Part B SNF claims in accordance with existing ABN instructions.**

Previous instructions may not have been precise with regard to timing of funds collected for SNF inpatient demand bills. In order to adhere to current policy in Chapter 1 (General Claims Processing), §30.1.1, of the MCPM, SNFs can only collect payment for non-covered charges billed on traditional demand bills when the beneficiary who received services is technically ineligible for Part A coverage. When a Part A inpatient is involved, the SNF may not collect funds until the intermediary has made a payment determination. **This restriction is an exception to all other demand billing situations,** where funds may be collected from beneficiaries in advance of the determination of liability resulting from medical review of a demand bill. If the result of such review is the beneficiary is not liable, any funds collected in advance must be returned.

2. General Demand Billing Instructions, Inpatient and Outpatient (Other than HH PPS and Part A SNF).

New with this instruction, in addition to current home health and SNF requirements (in II. D. 1. above), all other provider types, including HH service NOT paid under HH PPS (i.e., TOB 34x), AND inpatient services (TOBS 11x, 21x, 18x and 41x) are required to submit demand bills using condition code 20 when requested by beneficiaries. Traditionally, **hospices** are the only other category of providers that have received specific guidance from FIs/RHHIs on using this type of demand bill. FIs/RHHIs perform review of such bills, for reasons such as medical necessity, coverage and payment liability issues, although inpatient hospital bills (TOB 11x) are sent to the Quality Improvement

Organizations (QIO), formerly the Peer Review Organizations (PROs)) for medical necessity determinations exclusively.

However, for outpatient billing, this is ONLY in cases when an ABN is not given/not appropriate. Also, services that the provider is sure are non-covered, such as statutory exclusions outside a recognized Medicare benefit, should **never** be demand billed through this process UNLESS specifically requested by a beneficiary (i.e., the beneficiary wants a determination, not just billing for denial). Either interim bills, final bills or adjustment requests may be used to demand bill.

Other covered services may appear on these claims, but not other non-covered charges, as all non-covered charges on demand bills will be considered in dispute and in need of review. Allowing covered and non-covered services to come in on demand bills will allow all services provided in the statement covers period to be billed, though payment of the covered services will be delayed by the review and development of the non-covered charges. **For this reason, providers should break out demand billed services to separate claims for discrete time periods with all non-covered charges whenever possible.** Such claims must contain at least one non-covered charge at issue, or the claims with condition code 20 will be returned to the provider.

Funds may be collected from beneficiaries in advance of the determination of liability resulting from medical review of a demand bill (note exception for SNFs in III. D. 1. c., above). **If the result of such review is that the beneficiary is not liable, as when Medicare pays covered charges, any funds collected in advance must be returned.** Additionally, HHAs may not collect funds from beneficiaries or subsequent insurers for services for which they know they will be found liable, as they would once educated as to the need to correct routine use of the HHABN. That is, demand billing cannot be used as a red herring to hold or retain either beneficiary or subsequent insurer funds for any period of time when the HHA has reason to know they are fully liable for the services in question.

In summary, other general requirements for demand bills, other than SNF and HH PPS demand bills exceptions, are:

- **Condition code 20 must be used**;
- **All charges associated with condition code 20 must be submitted as non-covered**, all non-covered services on the demand bill must be in dispute, and at least one non-covered line must appear on the claim, but unrelated covered charges must be allowed on the same claim (unrelated non-covered charges not in dispute, if any, would be billed on a no payment claims using condition code 21 for outpatient bill types—see III. B. above);
- **Frequency code zero should be used if** all services on the claim are non-covered;

- **Conditions codes 20 and 32 (i.e., ABN) are NEVER submitted on the same claim;** and
- **Basic required claim elements must be completed**.

Unlike entirely non-covered outpatient claims using condition code 21, no claims may be submitted simultaneously with demand bills, EXCEPT no payment claims for outpatient bill types using condition code 21, with statement period equal to or fitting within the demand bill statement period. This is true even if only charges associated with the condition code 20 are submitted on the claim, and therefore it is an entirely non-covered claim. No payment bills using condition code 21 are only used for services that are **not** in dispute, as opposed to non-covered charges on demand bills. This restriction is required because some services on demand bills may be found covered upon review, unlike no payment claims where there is no expectation of coverage/payment. Avoiding overlaps with other than entirely no-payment claims will also prevent claims from being rejected as duplicates.

Also new with this instruction, providers should be aware CMS may require development of any non-covered charge on traditional demand bills. In addition to this review, such services will then be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion.

E. Billing with an ABN (Use of Occurrence Code 32) Comparable to Traditional Demand Bills

Now, using an ABN is frequently required, much more often than traditional demand billing, usually when medical necessity is in doubt, or other issues captured in §1862(a)(1) and §1879 of the Act apply, or when previous covered treatment is to be reduced or terminated within a Medicare benefit. Previous ABN instructions brought about a large change in billing practices, because before this time **covered** charges were never billed when medical necessity was in doubt. **Claims billed in association with an ABN never use condition code 20 or 21,** but instead:

- **Must use a claim-level occurrence code 32** to signify all services on the claim are associated with one particular ABN given on a specific date (**unless** the use of modifiers, discussed below, makes clear not every line on the claim is linked to the ABN);
- **Must provide the date the ABN was signed** by the beneficiary in association with the occurrence code;
- **Occurrence code 32 and accompanying date must be used multiple times if** more than one ABN is tied to a single claim for services that must be bundled/billed on the same claim (i.e., one date for one ABN lab services tied to a R-131-L, another for services tied to a R-131-G, even if the date is the same for both ABNs);
- **Must submit all ABN-related services as covered charges**; and

- **Must complete all basic required claim elements** as for other comparable claims for covered services.

Again, if an ABN is given, these billing procedures must be used, rather than traditional demand billing. **New with this instruction, providers should be aware CMS may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN.** Citations for instructions on the ABN, which include information on when an ABN is appropriate, are given above. If claims using occurrence code 32 remain covered, they will be paid, RTPed, rejected or denied in accordance with other instructions/edits applied in processing to completion. Denials made through automated medical review of service submitted as covered are still permitted after medical review, and the FI will determine if additional documentation requests or manual development of these services are warranted. For all denials of services associated with the ABN, the beneficiary will be liable.

F. Summary of Methods for Demand Billing [Table 4]

Providers must decide which condition and notice requirement is appropriate to the billing situation, and use **only one** of these options in each case, as follows:

TABLE 4:

Situation and Notice Requirement	Description/Charges	Applicable Providers
No ABN or HHABN required, beneficiary not in a HH PPS episode, but beneficiary requests a demand bill be submitted (i.e., for a service excluded by statute)	Claims use **condition code 20**, and submit charges in question as **non-covered** in accordance with demand billing instructions	**All outpatient/ hospice/inpatient Part B providers except HHAs paid under HH PPS** (i.e., all types of bill (TOB) submitted to FIs/RHHIs **except** 32x and 33x)
HHABN required OR service must be demand billed at beneficiary request during an HH PPS episode	Claims use **condition code 20**, and submit charges in question as **non-covered** according to directions for HH PPS demand bills	**Only HHAs paid under HH PPS (TOB 32x and 33x only)**
ABN required (**131-L** --lab services only; and **131-G** -- all other services)* **NOTE**: Modifiers required when services not related to ABN must be billed on same claim	Claims use **occurrence code 32**, report the date the ABN was signed, and all services related to the ABN are submitted as **covered** charges	**All outpatient/ hospice/inpatient Part B providers except HHAs paid under HH PPS** (i.e., all TOBs submitted to FIs/RHHIs **except TOB 32x and 33x**)

***** Use of this version of the form is optional. Providers delivering same-day lab and non-lab services related to an ABN may use CMS-R-131-G for both.

Same-day billing requirements under OPPS present a particular challenge. If a case occurred in which a OPPS hospital provided two services thought to be non-covered and in dispute on the same day, one for which an ABN was given and one without an ABN, the services would have to be submitted on two separate claims. One of these claims would be a demand bill using condition code 20 for the service not associated with the ABN, the other one a claim using occurrence code 32, which would contain the service associated with the ABN billed as covered, and could also contain other covered services provided that day (see Section III. H. below on the use of the –GA modifier). Both claims should process to completion, unless other edits apply, since claims using condition code 20 have always been exempted from the OPPS same day billing rule.

G. Line-Item Modifiers Related to Reporting of Non-Covered Charges When Covered and Non-Covered Services Are on the Same Claim [Tables 5 and 6]

Several Healthcare Common Procedural Coding System (HCPCS) modifiers are used to signify a specific line item is either not covered or not payable by Medicare, for many different reasons. The chart immediately below lists all those modifiers, many more commonly used by Medicare carriers, for services not covered or not payable by Medicare. **Modifiers not payable to carriers are also not payable to FIs/RHHIs**. These modifiers, not covered or payable by definition of the national HCPCS committee, along with other modifiers affecting payment that have been brought up in discussion of non-covered charges, are presented in the following chart:

TABLE 5:

Source of the Modifier List	Modifiers	Claims Processing Instructions	Definition Source
HCPCS Modifiers <u>Not Covered</u> or <u>Not Payable</u> by Medicare by Administrative Instruction Attached to Definition	-A1 through -A9, -GY, -GZ, -H9, -HA through -HZ, -SA through -SE, -SH, -SJ, -SK, -SL, -ST, -SU, -SV, -TD through -TH, -TJ through -TN, - TP through -TW, -U1 through -U9, -UA through –UD	**FI standard systems will deny all line items on all TOBs using these modifiers in all cases** as part of processing claims (if not fully implemented before, all will be denied with the implementation of this instruction); provider liability is assumed EXCEPT when noted as	Use as defined by 2003 publication of HCPCS codes by CMS

		beneficiary liable in accordance with the chart below (of the total set to the left: -GY, -TS)	

Source of the Modifier List	Modifiers	Claims Processing Instructions	Definition Source
CPT/HCPCS Modifiers Permitted on OPPS Claims (Transmittal/ PM: A-02-129)	**CPT**: -25, -27, -50, -52*, -58, -59, -73*, -74*, -76, -77, -78, -79, -91 **HCPCS**: -CA, -E1 through -E4, -FA, -F1 through -F9, -GA, -GG, -GH, -GY, -GZ, -LC, -LD, -LT, -QM, -QN, -RC, -RT, -TA, -T1 through -T9	**FI standard systems accept these modifiers for processing on OPPS claims (TOBs: 12, 13, 14**) in accordance with HCPCS/CPT definitions, and in accordance with chart below.	**CPT** numerical modifiers defined in 2003 publication of "CPT Manual" by the American Medical Association; **HCPCS** codes as defined by 2003 publication of HCPCS codes by CMS
Modifiers Used in Billing Ambulance Non-Covered Charges (Transmittal A-02-113, new instructions below)	-GY, -QL, -QM or -QN, -TQ, alpha destination modifiers	Applicable TOBs for ambulance billing: **12x, 13x, 22x, 23x, 83x, 85x**	**See ambulance instructions (III. I.) and chart immediately below**
Specific HCPCS Modifiers to Consider Related to Non-Covered Charges or ABNs	-EY, -GA, -GK, -GL, -GY, -GZ, -KB, -TS	FI standard systems accept some of these modifiers for processing as specified on the chart below with the implementation of this instruction	**See chart immediately below**

* These modifiers relate to situations where there is no notice requirement, because these charges occur either as treatment begins or after it has started, and Medicare simply reduces the payment to the provider.

In the past, modifiers were more frequently used to qualify procedure codes submitted on professional billing formats, such as Form CMS-1500, to entities like Medicare carriers. Use of modifiers has increased in institutional billing over time, though, unlike professional claims, institutional claims did not always require the use of procedure codes in addition to revenue codes.

By April 2004, when this instruction will be implemented, the Health Insurance Portability and Accountability Act (HIPAA) will require all submitters of electronic claims to use the 837 electronic format. The version of this format providers must use as of that time relates modifiers to associated procedure codes, including HCPCS (Form Locator 44 of the hard copy UB-92 claim). For this reason, CMS does not believe failing to require HCPCS on non-covered line items after this point will benefit institutional providers, and expects most vendors of billing software will program their products to require HCPCS procedure codes if modifiers are used. **Therefore, HCPCS coding is required on any non-covered line item using one of the modifiers described in this instruction.**

Providers should use explicit procedure or HCPCS coding to describe services and items they deliver, even when submitting these items as non-covered. In cases in which general HCPCS coding may be needed to submit a non-covered service for which Medicare institutional claims have not required HCPCS coding in the past, such as with drugs or supplies, the following HCPCS code can be used with the appropriate revenue code in order to employ a modifier:

A9270 Non-covered item or service

With the implementation of this instruction, FI/RHHI systems will accept this code, which, since it is non-covered by Medicare by definition, and will be denied in all cases. **Liability will rest with the provider, unless a modifier is used to assign liability to the beneficiary** (i.e., -GL, -GY, -TS), when the beneficiary has been informed, prior to service delivery, that he/she may be liable for payment. Note –GA cannot be used with this code since it requires non-covered charges. Modifiers most likely to be used with non-covered charges or liability notices are listed below.

TABLE 6:

Definition of Modifiers Related to Non-covered Charges/ABNs for FI/RHHI Billing

Modi-fier	HCPCS Modifier Definition	HCPCS Coverage/ Payment Admini-strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-EY	No Physician or Other Licensed Health Care Provider Order for this Item or Service	None	None, cannot be used when HHABN or ABN is required, recommend documenting records; **liability is provider unless**	To signify a line-item should not receive payment when Medicare requires orders to support delivery of a item or service (i.e., **TOBs 13x, 14x, 21x, 22x, 32x, 33x, 34x, 81x, 82x, 85x)**	**When orders required, line item is submitted as non-covered** and services will be denied

			other modifiers are used (-GL, -GY, or –TS)		

Modi-fier	HCPCS Modifier Definition	HCPCS Coverage/ Payment Admini-strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-GA	Waiver of Liability Statement on File	None	ABN required; **beneficiary liable**	To signify a line item is linked to an ABN when charges both related to and not related to an ABN must be submitted on the same claim	**Line item must be submitted as covered**; Medicare makes a determination for payment
-GK	Actual Item/Service Ordered by a Physician, Item Associated with a –GA or –GZ modifier	None	ABN required if –GA is used; **no liability assumption** since this modifier should not be used on FI claims	Use –GA or –GZ modifier as appropriate instead	**Claims submitted to FIs using this modifier should be returned to the provider with the implementation of this instruction**
-GL	Medically Unnecessary Upgrade Provided instead of Standard Item, No Charge, No ABN	None	Can't be used if ABN/HHABN is required, COPs may require notice, recommend documenting records; **beneficiary liable**	Use only with durable medical equipment (DME) items billed to the RHHIs (**TOBs: 32x, 33x, 34x**)	**Lines submitted as non-covered** and will be denied
-GY	Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit	Non-covered by Medicare Statute (ex., service not part of recognized Medicare benefit)	Optional notice only, unless required by COPs; **beneficiary liable**	Use on all types of line items on provider claims	**Lines submitted as non-covered** and will be denied

Modi-fier	HCPCS Modifier Definition	HCPCS Coverage/ Payment Admini-strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-GZ	Item or Service Expected to Be Denied as Not Reasonable and Necessary	May be non-covered by Medicare	Cannot be used when ABN or HHABN is required, recommend documenting records; **provider liable**	Since with this instruction, condition code 20 demand bills can be submitted by all FI provider types, and these bills can accept covered and non-covered charges, and non-covered charges on these bills are already specified as requiring medical review, this modifier will **not** signal review is needed, but is available for **optional use** on demand bills NOT related to an ABN by providers who want to acknowledge they didn't provided an ABN for a specific line	**Lines submitted as non-covered** and will be denied
-KB	Beneficiary Requested Upgrade for ABN, more than 4 Modifiers on a Claim	None	ABN Required; **if service denied in development**, **beneficiary assumed liable**	Use **only** on line items requiring more than [2 or] 4* modifiers on home health DME claims (**TOBs 32x, 33x, 34x**)	**Line item submitted as covered**, claim must suspend for development *
-QL	Patient pronounced dead after ambulance called	None	None, recommend documenting records; **provider liable**	Use only for ambulance services (TOBs: **12x, 13x, 22x, 23x, 83x, 85x**)	**Lines submitted as non-covered** and will be denied
-TQ	Basic life support by transport by a volunteer ambulance provider	Not payable by Medicare	None, recommend documenting records; **provider liable**	Use only for ambulance services (**TOBs: 12x, 13x, 22x, 23x, 83x, 85x**)	**Lines submitted as non-covered** and will be denied

Modi-fier	HCPCS Modifier Definition	HCPCS Coverage/ Payment Admini-strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-TS	Follow-Up Service	Not payable by Medicare	No notice requirement, unless COPs require, recommend documenting records; **beneficiary liable**	Use on all types of provider claims when services are billed as non-covered for reasons other than can be established with other coding/modifiers (i.e., -GY) when the beneficiary is liable for other documented reasons	**Lines submitted as non-covered** and will be denied

[* NOTE: Many provider systems will not allow the submission of more than 2 modifiers. In such cases, despite the official definition and the capacity of the FISS and APASS systems to take in four modifiers on a line with direct EDI submission, RHHIs should educate that it is appropriate to use this modifier when three modifiers are needed if there is a two-modifier limit]

All modifiers listed in the chart immediately above that may be submitted on non-covered line items need only be used for Medicare when non-covered services cannot be split to entirely non-covered claims; however, modifiers indicating provider liability cannot be used on entirely no payment claims for which the beneficiary has liability**.**

The modifier –GA should only be used when line items related to an ABN cannot be split to a separate claim with only services related to that ABN (occurrence code 32 demand bills). **Occurrence code 32 must still be used on claims using the –GA modifier, so that theses services can be linked to specific ABN(s). Both the –GA and –KB modifiers will suspend for review, and if these services cannot be reviewed, they must be released back into processing as covered charges.**

Modifier –GK should never be used on FI/RHHI claims. Claims using this modifier will be returned to providers for correction.

H. Clarifying Instructions for Outpatient Therapies Billed as Non-Covered, on Other than HH PPS Claims, and for Critical Access Hospitals (CAHs) Billing the Same HCPCS Requiring Specific Time Increments

Since January 1, 1999, claims for outpatient rehabilitative services, including certain audiology services and comprehensive outpatient rehabilitative facility (CORF) services,

require billing with HCPCS procedure codes and line item dates, so that proper payment can be made under the Medicare Physician Fee Schedule. Complete instructions for many provider types for such billing can be found in: §10-40.5, Chapter 5 (Outpatient Rehabilitation) of the MCPM.

Though these instructions are still current and should be followed, they did not previously discuss billing for non-covered charges. This PM updates this instruction in order to allow the submission of non-covered charges. **Outpatient therapies billed as non-covered charges are not counted toward the therapy cap unless subject to review and found to be covered by Medicare- – note hospital bills are not subject to this cap**. Modifiers presented in the previous section of this instruction can be used with therapies, in addition to therapy-specific instructions for the use of modifiers –GN, -GO and –GP (Transmittal AB-03-057).

Critical Access Hospitals (CAHS) -- Although CAHs are not addressed in §10 thru 40.5, Chapter 5 (cited above), since they are not subject to payment on a fee basis under the Medicare Physician Fee Schedule, they sometimes bill therapies using HCPCS that by definition give specific time increments like those discussed below. Therefore, CAHs should follow the instructions below if there is a need to bill non-covered increments.

When HCPCS codes required for reporting do not specify an increment of billing in their definition (i.e., 15 minute intervals), the unit for the line item is 1, and general instructions given above for billing non-covered charges, either by the line item or on no payment claims, can be followed.

Several of the outpatient therapy HCPCS codes, however, **do specify billing in specific time increments in their definition**, and current instructions state units reported on line items should be consistent with these definitions. In such cases, when both covered and non-covered increments are provided in the same visit on the same date of service, billing should be done as follows:

- **Use an ABN and modifiers when appropriate to explain non-coverage and payment liability of specific lines** when covered and non-covered increments of the same visit appear on the same claim (i.e., -GY, see above).

- **Report covered and non-covered units in separate line items,** even when part of the same visit, with one line item for all covered and non-covered increments in a visit, and another for all non-covered increments in that same visit.

- **Do not report non-covered line items that are part of a partially covered service on a separate no payment claim (i.e., using condition code 21);** always report them on the same claim with the separate lines for the covered portion of the service.

- **Services of less than 8 minutes for codes defined in 15-minute increments ~~can~~ could be billed as a separate line item of a single non-covered unit** (i.e., non-

covered charges are equal to total charges, service unit is 1), BUT such billing would be contrary to clinical and coding guidelines, and therefore should not be done.

- **Do not report non-covered line items as part of the required reporting of value codes 50, 51 and 52 for covered visits** (i.e., where all increments are non-covered and there are no covered charges for the line item, since these line items are either part of an already counted partially covered visit, or an entirely non-covered visit).

- Never split a single increment into a covered and non-covered portion.

I. New Instructions for Non-Covered Charges on Ambulance Claims [Table 7]

Transmittal A-02-113 presented one scenario in which non-covered ambulance miles would be billed: the statutory restriction that miles beyond the closest available facility cannot be billed to Medicare. This previous instruction only stated that non-covered miles beyond the closest facility had to be billed with HCPCS procedure code **A0888** ("non-covered ambulance mileage per mile, e.g., for miles traveled beyond the closest appropriate facility") on an entirely non-covered claim using condition code 21. While A0888 is still used for this purpose, and existing base requirements, such as reporting HCPCS, origin/destination and zip code, still stand, **otherwise instructions for reporting ambulance non-covered mileage charges change with this new guidance**.

There is no longer any need for providers to use any other past instruction for submitting non-covered charges, such as forcing an one-dollar amount onto a non-covered line. Medicare will now processing actual amounts of non-covered charges, when reported as such, in all cases.

With the implementation of this instruction, ambulance claims may use the –GY modifier on line items for such non-covered mileage, **so that such items can be billed on claims also containing covered charges, and liability be assigned correctly to the beneficiary for such line item(s).** This method of billing is preferable in this specific scenario, miles beyond the closest available facility, so that all miles for the same trip, perhaps with covered and non-covered portions, can be billed on the same claim. However, billing using condition code 21 claims will continue to be permitted, if desired, as long as all line items on the claims are non-covered and the beneficiary is liable. Additionally, unless requested by the beneficiary or required by specific Medicare policy, services excluded by statute do not have to be billed to Medicare.

When the scenario is point of pick up outside the United States, including U.S. territories, mileage is also statutorily excluded from Medicare coverage. However, such billings are more likely to be submitted on entirely non-covered claims using condition code 21. Also, this scenario requires the use of a different message on the Medicare Summary Notice (MSN) sent to beneficiaries.

There are two more scenarios in which billing non-covered mileage to Medicare may occur. One scenario is when the beneficiary dies after the ambulance has been called but before the ambulance arrives. Another is when a subsidy is received from another source (i.e., local municipality) or the vehicle is owned and operated by a governmental or volunteer entity. **New billing requirements for all these situations, including the use of modifiers,** are presented in the chart below:

TABLE 7:

Scenario	HCPCS	Modifiers*	Liability	Billing	Remittance Requirements	MSN Message
STATUTE: Miles beyond closest facility	A0888 on line item for the non-covered mileage	-QM or –QN, origin/destination modifier, **and** –GY unless condition code 21 claim used	Beneficiary	Bill mileage line item with A0888 **–GY** and other modifiers as needed to establish liability, line item will be denied; **OR** bill service on **condition code 21** claim, no **–GY** required, claim will be denied	Group code **PR** for patient responsibility, reason code **96** for non-covered charges	**1.1** "Payment for transportation is allowed only to the closest facility that can provide the necessary care; OR, El pago por la transportación está aprobado solo hasta la facilidad más cercana que pueda proveer el cuidado necesario."
========	= = = = =	= = = = = =	= = =	= = = = = = = = = = = =	= = = = = =	==========
Variation: **Pick up point outside of U.S.	Same as above	Same as above	Same as above	Same as above	Same as above	**16.10** "Medicare does not pay for this item or service"; OR, "Medicare no paga por este artículo o servicio"

Scenario	HCPCS	Modifiers*	Liability	Billing	Remittance Requirements	MSN Message
Beneficiary dies after ambulance is called	Most appropriate ambulance HCPCS mileage code (i.e., ground, air)	QM or –QN, origin/destination modifier, **and** –QL unless condition code –21 claim	Provider	Bill mileage line item with **–QL** and other modifiers as non-covered, line item will be denied	Group Code **CO** for contractual obligation, reason code **96** for non-covered charges	**16.58** "The provider billed this charge as non-covered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."
Subsidy or government owned	A0888 on line item for the non-covered mileage	-QM or –QN, origin/destination modifier, **and -TQ must be used for cost reporting purposes**	Provider	Bill mileage line item with A0888**,** and modifiers as non-covered, line item will be denied	Group Code **CO** for contractual obligation, reason code **96** for non-covered charges	**16.58** "The provider billed this charge as non-covered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."

***** Current ambulance billing requirements state that either the –QM or –QN modifier must be used on all services. The –QM is used when the "ambulance service is provided under arrangement by a provider of services," and the –QN when the "ambulance service is provided directly by a provider of services." Origin/destination modifiers, also required by current instruction, combine two alpha characters: one for origin, one for destination.

** This is the one scenario where the base rate is not paid in addition to mileage.

The mandatory use of the –TQ modifier, **new with this instruction**, is required so that cost to charge ratios can be correctly computed for cost reports for all charges for which Medicare is primary by contract. This is the one exception where such primary charges are **not** submitted as covered charges, because they have already been paid by another source. **This modifier is to be used anytime another source voluntarily pays for ambulance mileage, even if the type of organization does not fit the strict definition of the modifier (i.e., a governmental entity rather than a voluntary organization).**

Effective with this instruction, Medicare's shared system must pass ambulance mileage line items with this modifier to the Provider Statistical and Reimbursement (PS&R) system, even though such line items are billed as non-covered, and PS&R must accommodate the reporting of these non-covered charges for cost reporting use. These are the only ambulance non-covered line items that will pass to PS&R. If providers believe they have been significantly or materially penalized in the past by the failure of their cost reports to consider these non-covered charges, they may contact their FI about reopening the reports in question. FIs have the discretion to determine if the amount in question warrants reopening. CMS does not expect many such cases to occur.

J. Clarification of Liability for Preventive Screening Benefits Subject to Frequency Limits [Table 8].

Some Medicare preventive benefits are subject to frequency limits, and are also specifically cited at §1862 (a)(1) (F) ff.of the Act as subject to "medical necessity". There has been some confusion as to the basis of denial and how such services are adjudicated. When medical necessity is the basis for denial (i.e., §1862 (a)(1) (F) ff. of the Act), a ABN is necessary in order to shift the liability to the beneficiary, and special ABN-related billing must be used (see III. E. above). Services above frequency limits, however, had been considered non-covered services by some, and billed as such, not requiring ABNs. In these cases default liability in Medicare systems is the provider, unless specific billing methods and modifiers were used to signal beneficiary liability (see sections III A. and B. above).

Medicare FIs systems have been programmed with frequency as the primary reason for denial, and Medicare carrier systems have used medical necessity. **Effective with this instruction, FI systems must change so that medical necessity is the primary reason for denial. FIs must educate providers as to this change in policy and new required use of the ABN.**

Previously, CMS had confirmed ABNs were not required when frequency limits were exceeded in several different forums, so provider feedback can be expected and special educational efforts required. It also may be contrary to provider practices to submit services over the frequency limit as covered charges, as ABN billing requires; however, it can be pointed out that existing Common Working File (CWF) frequency edits should still result in the denial of these services. Remittance denial reason codes and MSN messages to be used effective with this instruction are listed below for beneficiary and provider liability should either circumstance occur:

TABLE 8

Preventive Benefit	HCPCS Code(s)	PROVIDER LIABLE (ANSI) Remittance Group and Reason Code	PROVIDER LIABLE MSN Message	BENE. LIABLE (ANSI) Remittance Group and Reason Code	BENE. LIABLE MSN Message
Screening mammography	G0202, 76092, 76083	CO – 57 [57: Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.]	15.21 The information provided does not support the need for this many services or items in this period of time but you do not have to pay this amount. [Le informacion proporcionada no justifica la necesidad do esta cantidad de servicios o articulos an este periodo de tiempo pero usted no tiene que pagar esta cantidad.]	PR – 57 [57: Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.]	15.22 The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service. [Le informacion proporcionada no justifica la necesidad do esta cantidad de servicios o articulos an este periodo de tiempo por lo cual Medicare no pagara por este articulo o servicio.]

Preventive Benefit	HCPCS Code(s)	PROVIDER LIABLE (ANSI) Remittance Group and Reason Code	PROVIDER LIABLE MSN Message	BENE. LIABLE (ANSI) Remittance Group and Reason Code	BENE. LIABLE MSN Message
Screening pap smear	G0123, G0143, G0144, G0145, G0147, G0148, P3000, Q0091	CO - 57	Ditto above	PR – 57	Ditto above
Screening pelvic exam	G0101	CO - 57	Ditto above	PR – 57	Ditto above
Screening glaucoma	G0117, G0118	CO - 57	Ditto above	PR – 57	Ditto above
Prostate cancer screening test	G0102, G0103	CO - 57	Ditto above	PR – 57	Ditto above
Colorectal cancer screening test	G0104, G0106, G0107, G0120, G0122	CO - 57	Ditto above	PR – 57	Ditto above

IV - General Operational Information on Non-Covered Charges

A. Processing of Non-Covered Charges in Medicare Claims Processing Systems [Table 9].

Questions have been raised as to whether non-covered charges are subject to all the same software modules and edits in processing as covered charges. The answer is no, but processing varies depending on how the non-covered charge is submitted.

Medicare uses code editors to assure policy requirements are met in processing claims. These requirements are expressed as edits in software reviewing procedural and diagnostic coding. The Medicare Code Editor (MCE) is a module used on inpatient claims, and the Outpatient Code Editor (OCE) is used on outpatient claims. **Entirely non-covered claims are not processed through OCE, though non-covered charges on claims with covered charges will process through these modules**. However, entirely non-covered demand bills using condition code 20 may ultimately be submitted to these modules after review if some charges are judged covered.

The OPPS OCE has two different edits that are applied to non-covered charges on claims with some covered charges (Edits 9 and 5). However, several OCE indicators may be applied to non-covered charges, and therefore there is no one-to-one correspondence of these indicators to specific scenarios for submission of non-covered charges, even statutory exclusions. These non-covered charges will be flagged for denial at this point or in subsequent processing.

Shared systems, also called standard systems, software, the Arkansas Part A and Fiscal Intermediary (APASS and FISS) standard systems, form the backbone of Medicare claims processing for Medicare institutional services. These systems link components of processing, such as code editors, Pricers, CWF, PS&R and the back-end remittance and MSN notices, and contain their own edits to assure accurate processing. Duplicate edits look for simultaneous services or claims submitted by the same provider for the same beneficiary. **Entirely non-covered claims and line items, except condition code 20 demand bills, are not subject to these duplicate edits**. Condition code 20 demand bills must be subject to these edits, since some services may be judged covered upon review.

Pricer software calculates the payment Medicare will make on a claim for many of Medicare's payment systems (i.e., OPPS**). Neither entirely non-covered claims, nor non-covered line items, are processed through Pricer software**.

The CWF is the segment of Medicare claims processing where several aspects of policy required for payment relative to a specific beneficiary are verified. For example, lifetime reserve days must be tracked for a beneficiary no matter what FI or standard system are involved in processing claims using these days. The CWF also has it own consistency edits to assure accurate payment and processing. **The CWF consistency edits will NOT be applied to entirely non-covered claims and line items unless these edits address the validity of required claim elements (i.e., HIC number, provider number). The CWF Part B duplicate edits will also NOT be applied to entirely non-covered outpatient claims and line items, nor will utilization edits or A/B cross-over edits.**

Claims or lines rejected as a duplicate payment need <u>not</u> be sent to CWF. The following types of rejects should not be sent to CWF:

- CWF and FI duplicates;
- CWF rejects for entitlement;
- CWF rejects for claims that overlap risk HMO periods;
- CWF rejects for hospice election periods; and
- CWF rejects for HH PPS Claims that overlap other HH PPS episodes.

The outpatient CWF records (HUOP and HUHH) have been expanded to create a non-covered revenue line field to accept and pass non-covered charges to the National Claims History (NCH) File. Non-payment codes are required in CWF records where no payment is made for the entire claim.

Claims with non-covered charges, other than the rejects listed above and submitted by providers or resulting from FI review or medical review (MR) must be forwarded to CWF with the appropriate American National Standards Committee, Accredited Standards Committee X12 (ANSI ASC X12) group, adjustment reason codes, as presented in Table 9 below and elsewhere in this instruction. This must be done for both non-covered charges and covered charges on otherwise covered claims, and entirely non-covered claims. FI shared systems must provide a complete CWF input record for these claims, totaling the charges on the CWF input under revenue code 0001 (covered and non-covered). When claims are totally non-covered (TOB = XX0, including condition code 21 or some demand bills with condition code 20), the reasons for non-coverage are shown on the 0001 line. Currently, Medicare systems are limited to carrying no more than four ANSI ASC X12 reason codes per line. If the services on a claim are non-covered for multiple reasons requiring more than four codes, report the first four codes appearing on the claim on the 0001 line.

Both the shared systems and CWF react to CMS-created non-payment codes on entirely non-covered claims. Standard systems must enter the appropriate code in the "Non-payment Code" field of the CWF record if the non-payment situation applies to all services present on the claim. Other than the distinct codes used for Medicare Secondary Payer (MSP) cost-avoided claims, entirely non-covered outpatient claims use either a “N” or “R” no-payment or “no-pay” code. The N and the R no-pay codes are defined in Chapter 1 (General Claims Processing), §60 of the MCPM. These codes do not in themselves establish payment liability. The codes function more to relay how interacting parts of Medicare systems should process and account for entirely non-covered claims; for example, with regard to tracking Medicare savings or utilization.

The R code should be used instead of the N code in all cases where a spell of illness must be updated. **Effective with this instruction, RHHIs that are currently using the N no-pay code in these cases, must change their practice and employ the R code consistently for all outpatient claims, including home health. Accordingly, the shared systems must update home health value codes 62-65 when the R code is used, filling the values associated with the codes as zeros, since these value codes are needed to effectuate information related to the A-B Shift in the home health spell. CWF consistency edits related to the R no payment code will be bypassed in these cases. The CWF will update the dates of earliest and latest billing activity (DOEBA and DOLBA) for the benefit period, but not for the episode.**

Clarification of cost reporting needs for ambulance services requires for the first time, effective with this instruction, non-covered charges be sent to the PS&R systems (see III. I. above). **This is currently the only instance of non-covered charges being sent to PS&R and used in cost reporting.**

After processing is complete, remittance notices, in the electronic 835 format, or standard paper format, are used to explain to providers the difference between the charges they submitted and what Medicare paid. The MSN is used to inform beneficiaries about payment for the services they received. Questions have been asked as to what remittance

or MSN messages should be used for submitted non-covered charges that are denied. **Unless more specific applicable requirements already exist, the following remittance and MSN messages can be used for denied non-covered charges.**

TABLE 9:

Liability	Remittance Requirement	MSN Message
Beneficiary	Group code **PR** for patient responsibility, reason code **96** for non-covered charges	**16.10** "Medicare does not pay for this item or service."; OR, "Medicare no paga por este artículo o servicio."
Provider	Group Code **CO** for contractual obligation, reason code **96** for non-covered charges	**16.58** "The provider billed this charge as non-covered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."

B. <u>Education</u>

The MCPM is simultaneously being updated to incorporate this information on non-covered charges. However, since patient liability notices and non-covered charges are current issues for many providers, FIs/RHHIs must educate all their provider types, as appropriate to the information presented in this change request, noting that: (1) The materials will be split to a few different locations in that manual; and (2) Not all the material is relevant to all providers. With these factors in mind, this information should be posted on FI/RHHI Web sites, and providers should be notified with listserv messages. The FIs/RHHIs may re-format the content contained herein for the most effective provider education based on their experience.